November 26, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0270-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is board certified in anesthesiology. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 39 year-old male who sustained a work related injury to his thoracic spine and chest on ___. The patient has been treated with physical therapy, rehabilitation and work hardening, and also received injection therapy, which failed to provide him with relief of his symptoms. The patient was referred by his treating physician to a pain and stress management center for assessment of mental health barriers that may be interfering with rehabilitation and treatment planning. ___ has suggested and is requesting preauthorization to proceed with behavioral pain management treatment five days a week for fur consecutive weeks for a total of 20 sessions.

Requested Services

Proposed Pain Management Program for 20 sessions.

Decision

The Carrier's denial of authorization and coverage for the requested services is overturned.

Rationale/Basis for Decision

___ physician reviewer indicated that the patient suffered an injury to his thoracic spine and chest on ___ due to a fall while carrying a pipe. ___ physician reviewer noted that the patient began treatment with a pain management specialist a short time after his injury and received therapy with analgesic medications. ___ physician reviewer also noted patient attended physical therapy and a 5 week course of work hardening. ___ physician reviewer further noted that the pain management specialist recommended a series of intercostal nerve blocks, but that the

patient did not pursue this therapy due to concerns abut possible side effects. ___ physician reviewer indicated that the patient also had an MRI of the thoracic spine in November 2001 that was unremarkable. Patient was then re evaluated by a designated, independent physician on 5/2/02 who concluded that he had reached maximal medical improvement and that his chronic pain disorder had psychological factors.

___ physician reviewer indicated the enrollee has a documented chronic pain syndrome that has not responded to primary and secondary levels of treatment. ___ physician reviewer explained that he continues to have significant pain with impairment in activities of daily living and an inability to return to work. ___ physician review also indicates that the patient has been fully evaluated and there is no surgically correctable process. ___ physician reviewer further noted that a multidisciplinary pain program will address both his pain behavior and the emotional distress related to his pain/injury. Therefore, ___ physician reviewer concluded that requested evaluation and treatment is medically necessary for treatment of his condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,